

STATE OF HAWAII, DEPARTMENT OF HEALTH
OFFICE OF HEALTH STATUS MONITORING

REQUEST FOR ☐ VERIFICATION ☐ CERTIFIED COPY OF **DEATH RECORD**

NAME OF DECEASED:			FIRST	MIDDLE	LAST
DATE OF DEATH:			MONTH	DAY	YEAR
PLACE OF DEATH:			CITY OR TOWN ISLAND		
SOCIAL SECURITY NUMBER: (VERIFICATION ONLY)					
RELATIONSHIP OF REQUESTOR TO PERSON NAMED ON CERTIFICATE			REASON FOR THIS REQUEST		
SIGNATURE OF REQUESTOR:				TELEPHONE NUMBERS	
PRINT NAME OF REQUESTOR:				RES:	
				BUS:	
ADDRESS OF REQUESTOR:			NO. AND STREET OR P.O. BOX		
CITY		STATE		ZIP	

<u>CERTIFIED COPIES:</u>		<u>FEES</u>	
_____ FIRST COPY AT \$10.00			= \$ _____
_____ ADDITIONAL COPIES AT \$4.00 EACH			= \$ _____
_____ TOTAL COPIES			TOTAL AMOUNT DUE = \$ _____
<u>VERIFICATION:</u>			
_____ COPIES AT \$5.00 EACH			TOTAL AMOUNT DUE = \$ _____
			GRAND TOTAL DUE = \$ _____

FOR OFFICE USE ONLY			
<div style="display: flex; justify-content: space-between;"> <div>_____ NR FILE</div> <div>_____ PENDING:</div> </div>			
FROM	INDEX SEARCHED TO	FROM	VOLUMES SEARCHED TO
YEAR	VOLUME	CERTIFICATE	DATE COPY PREPARED RECEIPT NUMBER